



**2009 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)
ENERGY CRISIS INTERVENTION PROGRAM (ECIP)
APPLIANCE REPAIR/REPLACEMENT PROGRAM**

The Community Action Partnership of San Bernardino County's (CAPSBC) Energy, Education and Environmental Services (EEES) program is taking applications for qualifying residents to receive assistance in repairing or replacing the following appliances:

- Heaters (October – March)
- Coolers (April – September)
- Hot Water Heaters (January – December)

TO BE ELIGIBLE, households must have one or more of the following individuals and meet the Department of Health and Human Services (DHHS) Poverty Income Guidelines. HHS monthly income guidelines begin at \$2,431.04 for a family of one and up to \$6,171.11 for a family of six:

- Seniors 60 years of age or older
- Disabled individuals receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI)
- Households with children 5 years of age or under

DOCUMENTATION REQUIRED:

- Gas and Electric bills (all pages to bills) at the time of applying
- Applicant's verification of income for the prior 30 days from date of application
- Proof of property ownership
- If RENTING, a form will be provided for the OWNER'S approval/signature

Please fill out the referral form on the reverse side and submit or fax it to:
COMMUNITY ACTION PARTNERSHIP OF SAN BERNARDINO COUNTY

696 S. Tippecanoe Avenue
San Bernardino, CA 92415-0610
FAX: 909/723-1629

OR

Call CAPSBC today at 909/723-1624 or 909/723-1500 or visit us at
www.capsbc.org



Community Action Partnership of San Bernardino County
E M E R G E N C Y HEATING/COOLING SERVICES
REFERRAL

NAME: _____

Address: _____

City, State and Zip Code: _____

Telephone/Message #: _____

(REQUIRED)

Ages of household members: _____

Permanently Disabled: ____ Yes ____ No

Have you received home weatherization services? ____ Yes ____ No

Have you applied for HEAP utility assistance? ____ Yes ____ No

Give a brief description of services needed:

Name of referring staff: _____

Agency/Dept. _____ Telephone _____

Date: _____

NOTE:

This is only a referral. This referral does not confirm eligibility nor guarantees assistance. Assistance is based on qualifying factors and funding availability.

***DO NOT SUBMIT ANY FORMS OR DOCUMENTATION WITH THIS REFERRAL.**
CLIENT INTAKE APPLICATION AND REQUIRED DOCUMENTATION WILL BE
TAKEN ON THE DATE OUR INSPECTOR CONDUCTS THE INITIAL INSPECTION.